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The University of Southern Mississippi

IDENTIFICATION AND PREVENTION OF SECONDARY TRAUMATIC STRESS  
IN MENTAL HEALTH PROFESSIONALS WHO WORK  
WITH CHILD SEXUAL ABUSE VICTIMS

by

Abby Duckworth McNeil

Abstract of a Capstone Project  
Submitted to the Graduate School  
Of The University of Southern Mississippi  
In Partial Fulfillment of the Requirements  
For the Degree of Doctor of Nursing

December 2012

ABSTRACT

IDENTIFICATION AND PREVENTION OF SECONDARY TRAUMATIC STRESS  
IN MENTAL HEALTH PROFESSIONALS WHO WORK  
WITH CHILD SEXUAL ABUSE VICTIMS

by Abby Duckworth McNeil

December 2012

Secondary traumatic stress (STS) is an issue that may be experienced by mental health professionals who are exposed to clients' trauma materials and become at risk of becoming traumatized themselves. Mental health professionals working with sexually abused children are more vulnerable to STS due to their empathic engagement and level of exposure to trauma. The impact of STS can result in poor productivity, increase in illness, and turnover rates for mental health professionals. Cumulative effects of STS make awareness and early intervention imperative. Research has shown that members of the helping profession suffer emotional and physical illness more often than other professions. The vicariousness of empathy or secondary trauma is discussed in the literature as the quality of putting oneself into another's shoes or situation. When you care for and take on another's feelings mental health professionals may be at risk for psychological and negative physical effects.

The purpose of this scholarly project was to a) identify the presence and level of STS symptoms; (b) provide a STS education program and prevention plan; and (c) evaluate the effectiveness of the STS program and prevention plan among mental health professionals who work with child sexual abuse (CSA) victims. After education and

prevention training, the mental health professionals developed a personal STS prevention plan and were evaluated again for symptoms of STS in five weeks.

Comparisons of mental health professionals' total STSS pretest and posttest scores were not statistically significant ( $t(15) = -1.102, p = .288$ ), with no reduction in scores. However, there is evidence of STS in the survey population. The majority ( $n = 7, 44\%$ ) of the participants ( $N = 16$ ) experienced mild symptoms of STS and may be experiencing negative effects of STS. The most frequently reported STS symptom was avoidance related to work with clients.

Implications for practice include increased awareness, identification and prevention of STS. This may decrease staff illness and turnover rates and increase productivity. The ability of mental health professionals to empathetically engage with the client without symptoms of STS may ultimately improve the therapeutic relationship and patient outcomes.



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December 2012



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## LIST OF ABBREVIATIONS

CFST	Compassion Fatigue Self-Test
CSA	Child Sexual Abuse
CSDT	Constructivist Self-Development Theory
DIQ	Demographic Information Questionnaire
DNP	Doctorate of Nursing Practice
<i>DSM-IV-TR</i>	Diagnostic and Statistical Manual of Mental Disorders, 4 <sup>th</sup> ed., text revision
MHP	Mental Health Professionals
PTSD	Post Traumatic Stress Disorder
SANEs	Sexual Assault Nurse Examiners
STS	Secondary Traumatic Stress
STSD	Secondary Traumatic Stress Disorder
STSS	Secondary Traumatic Stress Scale
TSIBS	Traumatic Stress Institute Belief Scale
VT	Vicarious Traumatization

## CHAPTER 1

### INTRODUCTION

Children and adolescent survivors of sexual abuse are an underserved, vulnerable population and experience the health disparity of inadequate access to and poor quality of mental health care services (Cohen, Deblinger, Mannarino, & Steer, 2004).

According to the U S Department of Health and Human Services, nearly 80,000 children are victims of sexual abuse (USDHHS, 2007). It is also estimated that only one in 20 cases of child sexual abuse (CSA) is identified or reported to the authorities. There is an increased incidence of co-morbid psychiatric diagnosis occurring in adults who are victims of CSA; 56% in women and 47% in men (Honor, 2010). In order to address health care disparities and improve health care outcomes among CSA victims when seeking mental health care services, mental health care professionals (MHP) need to provide quality and effective care.

Mental health professionals often care for persons exposed to traumatic events and over time can suffer from Secondary Traumatic Stress (STS). STS can affect the individual, family, organization, and the community. STS symptoms (intrusion, avoidance, and arousal) may lead to job dissatisfaction or burnout. Identification of mental health professionals at risk for and early prevention of secondary traumatic stress is essential in order to improve outcomes for patients exposed to traumatic events. Risk reduction through education may assist mental health professionals in the prevention of secondary traumatic stress.

#### Background and Significance

##### *Vicarious Traumatization*

Mental health professionals' exposure to trauma-based experiences of their clients has been described as vicarious traumatization, secondary traumatic stress, and burnout and compassion fatigue. Although there are a number of terms and overlapping concepts, vicarious traumatization focuses on the cognitive schemas or core beliefs of the therapist and the way in which these may change as a result of empathic engagement with the client (Bober & Regehr, 2006). Mental health professionals are involved in emotional and intense counseling with the client and can become empathically engaged in the pain the client is experiencing. The concept of vicarious traumatization was introduced by McCann and Pearlman (1990) to describe how psychotherapy work with trauma victims can cause distress in mental health professionals. Vicarious traumatization has been defined by Helm (n.d.) as the therapists inner experiences and view of the world are affected by exposure to trauma. Pearlman and Saakvitne (1995) describes vicarious trauma as a process of exposure to traumatic material repeated over time. Therapists working with victims of trauma have excessive demands upon their mental and physical resources. According to McCann and Pearlman (1990), these demands can lead to vicarious trauma, described as a general disruption to the function of the body and mind. The negative cognitive changes resulting from vicarious trauma include cognitive changes involving fear, trust, safety, power, independence, esteem, and intimacy. Vicarious trauma has a cumulative effect and occurs over time; therefore, awareness is a primary concern.

### *Secondary Traumatic Stress*

Secondary traumatic stress describes professional workers' subclinical or clinical signs and symptoms of Post-Traumatic Stress Disorder (PTSD) that mirror those experienced by trauma clients, friends, or family members (Bride, 2004). While it is not

recognized by current psychiatric standards as a clinical disorder, many clinicians note that those who witness traumatic stress in others may develop symptoms similar to or associated with PTSD.

According to Figley (1995), STS is the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event. Figley's (1995) criterion for Secondary Traumatic Stress Disorder (STSD) includes a stressor, which is an experienced event outside the range of usual human experiences that would be markedly distressing to almost anyone. Figley describes STSD as when symptoms continue six months or more following the exposure to traumatic material. Secondary traumatic stress reaction (STSR) is described as symptoms one month or less in duration and is considered a normal acute stress reaction. This stressor is then followed by three phases: re-experiencing of the trauma event, avoidance/numbing of reminders of the event, and persistent arousal. The re-experiencing of the trauma phase includes recollections of the event, dreams of the event, sudden re-experiencing of the event, and reminders of the distressing event. The avoidance phase includes efforts to avoid thoughts or feelings and activities related to the event, psychogenic amnesia, diminished interest in activities, detachment from others, a diminished affect and a sense of foreshortened future. The persistent arousal phase includes difficulty falling/staying asleep, irritability, difficulty concentrating, hyper vigilance, exaggerated startle response, and physiologic reactivity (Figley, 1995). Trauma therapy with children who have been sexually abused involves the therapist internalizing the process and attempting to integrate the traumatic material into cognitive schemas.

*Post-Traumatic Stress Disorder*

Post-traumatic stress disorder (PTSD) is different from STSD in that it involves actual exposure to the event. According to Bell, Kulkarni, and Dalton (2003), vicarious trauma can result in physiological symptoms that resemble post-traumatic stress reactions. The American Psychiatric Association (2000) describe PTSD criteria as intrusive symptoms of flashbacks, nightmares, and obsessive thoughts, feelings of numbness and disassociation, and disruption of cognitive schema. The intensity of working with traumatized individuals can negatively impact the well being of mental health professionals. These effects can be immediate symptoms associated with post-traumatic stress and longer-term effects in terms of altered belief systems (Bober et al., 2006).

Mental health professionals who work with trauma victims are at risk for developing vicarious traumatization or STS as evidenced by emotional and physical distress (McCann & Pearlman, 1990). Symptoms that may be exhibited in addition to symptoms of PTSD are irritability, digestive problems, fatigue, and sleeplessness. Research has shown that individuals in the helping professions suffer emotional and physical illness more often than individuals in other professions (McCann & Pearlman, 1990b). The comparison of the *DSM-IV-TR* Criteria for PTSD and Figley's Criteria for Secondary Traumatic Stress Disorder (STSD) illustrates the similarities (Appendix A).

#### *Burnout and Compassion Fatigue*

Other terminology that has been used to describe MHP exposure to their patients' trauma based experiences are burnout and compassion fatigue. Burnout refers to the cumulative psychological strain of working with many different stressors (Trippany, White-Kress, & Wilcoxon, 2004). Trippany et al. (2004) describes burnout as related to feeling overloaded due to chronic and complex clients whereas VT is specific to client



traumatic materials. It often manifests as a gradual wearing down over time.

Compassion fatigue, coined by Figley (1995), is considered a more severe example of cumulative compassion stress. It is defined as a result of prolonged exposure to compassion stress that leads to mental and physical exhaustion. Burnout and compassion fatigue are used interchangeably and can occur with any client group.

### *Empathy*

Empathy as a concept is an important aspect of nursing care and interpersonal communication skills. The primary purpose of empathy as discussed by Rogers (1980) is to effect therapeutic change. The therapeutic nurse-patient relationship is the core component within which to demonstrate empathy, offering of self and conveying this understanding to the client. Empathy's intent is to express understanding of the client, which promotes positive treatment outcomes. The behavioral responses are easier to measure and analyze, unlike emotional responses. Empathy is the ability to identify with the other person and truly understand and feel their pain and joy.

Mental health professionals utilize empathy when caring for victims of child sexual abuse. The concept of empathy and other similar terms found in the scientific literature include; sympathy, controlled empathy, somatic empathy, burnout, compassion fatigue, vicarious trauma, traumatic counter transference, and secondary post-traumatic stress disorder (McCann & Pearlman, 1990). Vicarious trauma has been defined as taking on the other person's feeling, while empathy is an understanding of another's feelings and situation. Being empathetic refers to the behaviors, skills, and abilities related to empathy. McCann and Pearlman (1990) defined vicarious trauma as a result of empathetic engagement with the client's trauma experience and narrative. The intense empathetic response of care providers working with trauma victims places

them at a higher risk for secondary trauma. When mental health professionals care and take on another's feelings they may be at risk for psychological and physical negative effects. Thus mental health professionals are more vulnerable to this phenomenon and subsequent secondary stress symptoms.

### Problem Statement

Secondary traumatic stress (STS) is an issue experienced by mental health professionals who are exposed to traumatic material and become at risk of becoming traumatized themselves. Mental health professionals working with sexually abused children are more vulnerable to STS due to their empathic engagement and level of exposure to trauma. STS can result in poor productivity, increase in staff illness, and turnover rates. Cumulative effects of STS make awareness and early intervention imperative.

### Review of the Related Literature

This literature review examines the effects of secondary trauma on mental health professionals. It is assumed that working with traumatized clients can have negative effects on the mental health professional. Similar concepts were described through the review of literature on vicarious traumatization, compassion fatigue, burnout, post-traumatic stress, and controlled empathy. The following synthesis of the literature review confirms the relationship between STS and exposure to client traumatic material.

#### *Vicarious Trauma*

In the research article by Bober and Regehr (2006), two specific questions were addressed for guiding the study. First, to assess whether therapists believed and engaged in commonly recommended forms of prevention for secondary and vicarious trauma, and whether engaging in these activities resulted in lower levels of distress. In this study

of 259 therapists, the amount of time spent with counseling trauma victims was the best predictor of trauma scores. The participants completed a self-report questionnaire format of the The Impact of Event Scale, The Traumatic Stress Institute Belief Scale, and The Coping Strategies Inventory. Although participants generally believed in the usefulness of recommended coping strategies, including leisure activities and supervision, these beliefs did not translate into time devoted to engaging in the activities. Most importantly, there was no association between time devoted to coping strategies and traumatic stress scores. It was recommended that organizations must determine ways of distributing workload in order to limit traumatic exposure of any one worker. It is clear that further research is needed regarding workplace conditions, and individual strategies that would prevent, identify, or reduce vicarious and secondary trauma among therapists is urgently needed.

Trippany et al. (2004) discussed the implications of the Constructivist Self-Development Theory (CSDT) with vicarious traumatization (VT) for preventing and managing counselor VT. According to the CSDT, there are five components of the self and one's perceptions of reality that are developed: frame of reference, self-capacities, ego resources, psychological needs, and cognitive schemas, memory, and perception. These CSDT components reflect the areas in which counselors' distorted beliefs and VT reactions occur. Counselors experiencing VT may feel there is no safe haven to protect them from real or imagined threats to safety. A counselor's inherent trust needs make him or her vulnerable to VT. Counselors may feel inadequate and question their abilities to help someone. They may push away from others or become increasingly dependent on significant others. They may experience feelings of helplessness and/or attempt to over control in other areas. Trippany et al. (2004) describes ways for counselors to

engage in prevention of VT through self-care. One way to prevent VT is by limiting the number of trauma clients per week to minimize the exposure to trauma material. Peer supervision provides benefits of consultation with colleagues and an opportunity to debrief and express reactions. Ongoing education and professional development resources for trauma counselors could decrease the impact of VT. It is recommended to provide self-care by maintaining a balance of work, play, and rest. Mental health professionals must apply their strengths and resources to themselves in order to prevent VT.

Bell, Kulkarni, and Dalton (2003), in a review of the organizational components of VT, suggested changes in the organizational culture to prevent vicarious trauma. Many professionals risk vicarious traumatization through contact with traumatized people or material with graphic images of trauma. Approximately 38% of social workers experience moderate to severe levels of secondary traumatic stress. Emergency workers, police officers, sexual assault counselors, child protective workers, and trauma therapists have all documented post-traumatic stress reactions to trauma material (Bell et al., 2003). Organizational recommendations included limiting workload of trauma clients, safe and comfortable work environment, trauma specific education, peer support groups, effective supervision, and resources for self-care. Bell et al. (2003) states that, while this may be costly for an organization, neglecting the employee may also be costly to the agency in terms of staff turnover and low morale.

According to Helm (n. d.), exposure to traumatic material can affect mental health professionals across modalities and theories. Play therapists have a greater exposure to traumatic material. Witnessing traumatic events through play may increase the susceptibility of the play therapists to experiencing vicarious trauma. Prevention and

intervention efforts should occur within wellness, organizational, supervision, and education. Wellness should be addressed from physical, psychological, interpersonal, behavioral, and spiritual aspects. It is important to consider whether the organization provides support and assistance when the employee is struggling. Ongoing supervision and education is essential to prevent vicarious traumatization.

Pross (2006) discussed the effects of vicarious traumatization and prevention strategies. Preventative factors considered were self-care, professional training, self-awareness, ongoing supervision, continuing education, and keeping a balance between empathy and proper boundaries with clients. Pross recommended that therapists not only treat traumatized clients or have reduced hours spent with trauma victims. The work environment must encourage flexibility and creativity while promoting continuing education and supervision.

McCann and Pearlman (1990b) were first to identify the concept of vicarious trauma as a theoretical framework for understanding sexual abuse trauma therapy on mental health professionals. As mentioned earlier, the constructivist self-development theory is the context in which psychological responses to victimization occurred. Mental health professionals who treat sexual abuse are exposed to many ways people violate the trust of others. This trauma exposure disrupts the cognitive schemas about trust, which leads to the mental health professionals becoming more distrustful of others (McCann & Pearlman, 1990b).

Pearlman and MacIan (1995) conducted a study of vicarious trauma effects on 188 self-identified trauma therapists. The findings measured by the Traumatic Stress Institute Belief Scale (TSIBS) identified that the new trauma therapists experienced more psychological difficulties. The trauma therapists with personal histories of trauma

had more negative effects from working with trauma victims. The recommendations included more training about trauma therapy, clinical supervision, and more support for new trauma therapists and survivor trauma therapists. Other studies in the field of trauma suggest that vicarious traumatization is an occupational hazard resulting from empathetic engagement with trauma victims (Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995).

Johnson and Hunter (1997) studied vicarious trauma in counselors working in sexual assault service and counselors working in nonsexual assault services. The results indicated that the counselors experienced higher levels of emotional exhaustion and reported using more avoidant strategies. They also scored higher on the intimacy factor relating to personal relationships outside of work. This study supports McCann and Pearlman's (1990) concept of vicarious trauma and relationship problems.

Schauben and Frazier (1995) correlated psychological distress with the percentage of trauma clients in a therapist's caseload. The study reviewed 148 female counselors who worked with sexual abuse survivors. The results proved that counselors with a higher trauma caseload reported more symptoms of PTSD and were more likely to experience vicarious trauma and belief disruption.

Follette, Polusny, and Milbeck (1994), studied law enforcement and mental health professionals and the impact of providing clinical services to CSA survivors. The mental health professionals reported low levels of psychological distress, PTSD, or trauma symptoms and moderate levels of personal stress. This study indicated that personal stress and types of coping affected the development of PTSD symptoms. Another finding that contradicts other studies was that the proportion of trauma caseload and personal trauma history did not indicate vicarious traumatization.

Jenkins and Baird (2002) examined the associations among measures of STS and vicarious traumatization using established measurement instruments: the TSIBS, Revision L (Pearlman, 1996), and the Compassion Fatigue Self-Test (Figley, 1995). Their research was conducted with a sample of 99 sexual assault and domestic violence counselors. The results indicated that there were both similarities and differences in the ways that the therapists experienced STS and vicarious traumatization. The study did support that secondary traumatic stress is a disorder commonly experienced by trauma counselors.

In a survey of 100 outpatient psychotherapists, Kassam-Adams (1995) found childhood history of trauma to be a significant predictor of PTSD-like symptoms when working with trauma survivors. Also, the results indicated that therapists with high trauma caseloads reported intrusive and avoidant secondary stress symptoms. Some have argued that STS symptoms are inevitable in trauma workers (Herman, 1992) and may occur regardless of caseload or childhood history of trauma. The overall findings from different studies appear somewhat mixed; however, they do point to higher risk factors with mental health professionals who work with trauma populations.

Organizations should be aware of potential risk factors for mental health professionals and attempt to address them. These risk factors include a personal history of trauma, lower levels of education and training, a shorter length of career, large trauma caseload, and long working hours (Beaton & Murphy, 1995). Some studies have shown gender to be positively correlated with STS, in that women are more likely than men to exhibit STS symptoms (Kassam-Adams, 1995). In addition, Beaton and Murphy (1995) discussed that the repercussions of not addressing secondary traumatic stress in mental

health professionals could result in emotional and physical disorders, strains on interpersonal relationships, substance abuse, and burnout.

### *Secondary Traumatic Stress*

Townsend and Campbell (2009) examined secondary traumatic stress among 110 sexual assault nurse examiners (SANEs). The study participants were females (99%) with bachelor's degree's (43%). The average number of years working as a SANE was 5.16. Figley's (1995) Compassion Fatigue Self-Test (CFST) was utilized to measure STS. Results showed that one-fourth of the forensic nurses experienced some STS symptoms after sexual assault examinations. The variables relating to higher levels of STS included more organizational support, more diffuse goals, greater prosecution orientation, and higher caseloads. Protective variables against STS included peer support, satisfaction with compensation, SANE-only facilities, older age, and more education.

In a study by Chrestman (1995), secondary exposure to trauma and self-reported distress among therapists was associated with increased symptoms of intrusion, avoidance, dissociation, and sleep disturbance. A higher trauma caseload was associated with secondary trauma symptoms. The study also found that decreased secondary trauma symptoms were associated with increased professional experience, increased income, and additional training.

According to Beck (2011), secondary traumatic stress was examined in nurses. The presence of STS was reported in forensic nurses, emergency department nurses, oncology nurses, pediatric nurses, and hospice nurses. The three STS measurement tools utilized were Secondary Traumatic Stress Scale (STSS) (Bride, Robinson, Yegidis, & Figley, 2004), Compassion Fatigue Self-Test for helpers, and the Compassion Fatigue



Scale- R. Beck (2011) suggested future studies to measure secondary traumatic stress with larger samples and nurses across all disciplines.

Dominguez-Gomez and Rutledge (2009) studied secondary traumatic stress in 67 emergency department nurses from three community hospitals utilizing the Secondary Traumatic Stress Scale (STSS) (Bride, Robinson, Yegidis, & Figley, 2004). The sample was largely female (67%) associate nursing degree-holders (58%). The results of this study revealed emergency department nurses (33%) met the criteria for STS symptoms. The most commonly reported symptom involved intrusive thoughts about patients. For the avoidance subscale, the most frequently reported symptom was avoidance of patients. In the arousal subscale, more than half reported difficulty sleeping and being easily annoyed. The STSS was also utilized to measure STS in 43 oncology nurses via a mail survey (Quinal, Harford, & Rutledge, 2009). The sample consisted of women (91%) with 39.5% holding associate's degrees and 37.2% bachelor's degrees. Utilizing the STSS (Bride et al., 2004), 16 oncology nurses (38%) experienced secondary traumatic stress symptoms. The participants reported difficulty sleeping, intrusive thoughts about patients, irritability, foreshortened future, and diminished activity level.

Bride (2007) measured secondary traumatic stress among social workers using the Secondary Traumatic Stress Scale (STSS). The STSS examined the frequency of individual symptoms, the frequency with which diagnostic criteria for post-traumatic stress disorder (PTSD) are met, and the severity of STS levels. Social workers engaged in direct practice are highly likely to be secondarily exposed to traumatic events through their work with traumatized populations. Many social workers are likely to experience at least some symptoms of STS, and a significant minority may meet the diagnostic criteria for PTSD. The analysis of demographic information revealed that study

participants were primarily female (81.9%) and Caucasian (77.5%). Respondents averaged 16.15 years in practice, and worked an average of 39.99 hours per week. Results indicated that 55% of the respondents met at least one symptom for diagnosis of PTSD, approximately 20% met two, and 15.2% met all three core diagnostic criteria for PTSD. The most frequently reported symptom was intrusive thoughts related to trauma work, with 40.5% of respondents indicating that they thought about their work without intending to. Experiencing psychological distress or a physiological reaction in response to reminders of work with traumatized clients were the next most frequently reported symptoms, with 19.1% and 12.4% of respondents reporting these symptoms, respectively. The two remaining intrusion symptoms were reported much less frequently, with 5.8% reporting distressing dreams and 5.0% reporting a sense of reliving the trauma(s) reported by clients. Bride (2007) estimates the rate of PTSD in social workers due only to indirect exposure is twice that of the general population. The experience of STS is believed to be one reason why mental health professionals may leave their field of work prematurely. Bride describes STS as an occupational hazard of providing direct services to the traumatized population. Limitations of this study were that the nonrespondents could be different from respondents and that the study was confined to licensed master's-level social workers, which may not be indicative of other mental health professionals.

#### *Compassion Fatigue/Burnout*

Compassion fatigue is a term often used interchangeably with secondary traumatic stress. Figley (1995) refers to compassion fatigue as a term exclusively used for individuals in the helping profession. According to Figley (1995), compassion fatigue or secondary traumatic stress disorder occurs in trauma therapists in response to

exposure to traumatic material. Figley categorized Secondary Traumatic Stress Disorder (STSD) as a cluster of symptoms similar to Post-Traumatic Stress Disorder. Figley discussed the difference of PTSD involves the actual exposure to trauma, and STSD involves the exposure to traumatic material. The phenomenon of STSD involves a sense of helplessness, confusion, and isolation (Figley, 1995).

Dutton and Rubinstein (1995) defined three areas of negative responses that clinicians may experience with trauma clients: indicators of psychological distress or dysfunction, cognitive shifts, and relational disturbances. The first category includes psychological dysfunction including distressing emotions, somatic complaints, intrusive imagery, numbing/avoidance behaviors, addictive/compulsive behavior, physiological arousal, and impairment of daily functioning. The second category of negative responses involved a shift in the clinician's cognitive schemas with alterations in beliefs, expectations, esteem, intimacy, and frame of reference. The third category involved personal and professional relationship disturbances. These disturbances led to increased stress and difficulty with intimacy (Dutton & Rubinstein, 1995).

Abendroth and Flannery (2006) examined compassion fatigue in 216 hospice nurses in Florida using the Compassion Satisfaction and Fatigue test. The sample participants were (94%) female, with 20.19 mean years of work. They had 5.65 mean years of hospice experience and 46.8% held associate's degrees. Results indicated 26.4% of the hospice nurses were at high risk and 52.3% were at moderate risk for compassion fatigue.

### *Empathy/Controlled Empathy*

Empathy is an understanding of another's feelings and situation. Being empathetic refers to the behaviors, skills and abilities related to empathy. McCann and

Pearlman (1990) relate vicarious trauma as a result of empathetic engagement with the client's trauma experience and narrative. The intense empathetic response of care providers working with trauma victims places them at a higher risk of vicarious trauma. There is emerging evidence that the empathetic response is an autonomic arousal and therefore difficult to control. Thus, care providers are more vulnerable to this phenomenon and subsequent post-traumatic stress symptoms.

*Merriam-Webster Dictionary* (2010) defines empathy as “the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner; *also*: the capacity for this” (def.2). The origin of empathy is Greek for “*empathia*, literally, passion from empathes emotional, from *em* + *pathos* feelings” (Merriam-Webster, “origin”). Nursing was related to empathy most recently, but prior to 1950 the concept of sympathy was used with nursing interactions (Morse et al., 1992). Controlled empathy is described by Izzo and Carpel (2007) as the autonomic responses that occur when therapists hear trauma narrative's, the brain struggles to remain composed or to hold back emotion and this interruption can lead to increase strain on the physical, cognitive, emotional, and spiritual well-being. Controlled empathy is an attempt by the body to protect itself from the negative effects of internalizing trauma.

Alligood (1992) discusses two types of empathy, basic and trained empathy. Basic empathy is developed from childhood to adulthood and is the innate capacity. Trained empathy is built on basic empathy and is developed through practice. Basic empathy is more the feeling aspect, while trained empathy is the cognitive component. Morse et al. (1992) divided empathy into moral, behavioral, cognitive, and emotive

components. The moral component is internalized by the ability to empathize with others. The behavioral component involves communication skills or the interpersonal relationship that the caregiver has with the client. The cognitive component involves the ability to understand the feelings of the person who is being given empathy. The emotive component is the vicariousness of empathy or the ability of the therapist to share their feelings. The behavioral component is the only one that can be observed and measured; this contributes to difficulty in fully analyzing the concept of empathy.

### *Review of Literature Summary*

The literature review recommended that a healthy work environment with organizational support and supervision would be helpful in the prevention of secondary traumatic stress. Prevention strategies included ongoing training with trauma therapists and decreasing the trauma caseload. It is also important that mental health professionals be aware of secondary traumatic stress and balance work and play while caring for their own well-being. In the end, these recommendations are likely to lead to a healthier environment for workers and to a higher quality of service for clients. The vicariousness of empathy is an essential component of the client-therapist relationship. This empathetic engagement with trauma clients increases the risk of secondary trauma in mental health professionals. There is a gap in empirical studies related to secondary traumatic stress in mental health professionals who work with child sexual abuse victims. There is a need to identify mental health professionals at risk for STS and provide education to help prevent this phenomenon.

### Theoretical Background

The Integration of Secondary Traumatic Stress framework developed by Harris (1995) provides an understanding of STS in mental health professionals who work with

victims of child sexual abuse. This framework identifies factors that can influence the development of secondary traumatic stress. According to Harris (1995), trauma workers work through phases after a critical traumatic incident. The first phase involves confronting the secondary traumatic stress (STS). During this phase there are a series of behaviors and feelings that occur in attempts to manage the psychological response following the critical incident. The second phase is described as the period of safety. The traumatic event is over physically but not emotionally. During this phase the emotional consequences are integrated into one's self. This safety period signals the onset of secondary traumatic stress reaction (STSR) phase. The third phase is the STSR, or the period when the trauma worker assimilates and accommodates the experience into his or her world. These behaviors and feelings are an attempt to integrate memories of the trauma and aftermath. This is a critical phase; either the trauma worker moves toward successfully integrating the STS or is unsuccessful and moves toward emotional immobility. The final phase is the integration, during which the trauma worker either successfully or unsuccessfully integrates the STS. Unsuccessful integration of STS results in secondary traumatic stress disorder (STSD). Acute STSD involves continual attempts and failure to integrate STS. Chronic STSD occurs when attempts of integration stop and the trauma worker is victimized by the traumatic event (Appendix B). A continuum or progression of negative responses that clinicians experience with exposure to trauma narrative/material is shown in Appendix C (adapted from Dutton and Rubinstein, 1995).

#### Project and the DNP Essentials

This project will address how to assist mental health professionals in the development of behavioral skills of empathy while avoiding secondary traumatization.

In order to provide effective mental health services, the effects of STS must be assessed and prevented.

The DNP's role is to translate research into evidence-based practice. The American Association of the College of Nursing (2006) describes the eight Doctorate of Nursing Practice (DNP) essentials for evidence-based practice (Appendix D). The DNP role will practice as a patient advocate and leader while addressing health disparities in the community. The goal of the current intervention is to prevent STS in mental health professionals, thus improving therapist-client interactions and improving patient care outcomes.

#### Project Objectives

The purpose of this scholarly project was to (a) identify the presence and level of STS symptoms; (b) provide a STS education program and prevention plan; and (c) evaluate the effectiveness of the STS program and prevention plan among mental health professionals who work with child sexual abuse (CSA) victims. The Secondary Traumatic Stress Scale (STSS) will be used to identify the presence and level of STS symptoms. After education and prevention training, the mental health professionals will develop a personal STS prevention plan and will be evaluated again for symptoms of STS in five weeks. Subsequently, mental health professionals' STSS pretest and posttest scores will be compared five weeks after education and prevention planning have been implemented to evaluate reduction in STS symptoms.

## CHAPTER II

### METHODS

#### Data Collection

A pre and posttest design was used to identify STS and evaluate an educational program about STS on MHP who work with victims of child sexual abuse. The research approach is quantitative, utilizing the secondary traumatic stress scale (STSS) to measure secondary stress symptoms of intrusion, avoidance, and arousal. The rationale was to administer the STSS pretest to identify MHP with STS symptoms. A posttest STSS was administered five weeks after education, and a prevention plan was implemented to evaluate for a reduction in STSS scores.

#### *Setting*

The setting was a community-based mental health clinic in the Southwest part of Mississippi that provides rural community mental health services for children and adolescents. The mental health services are administratively organized through a service line structure that operates community mental health services in the state. The Executive Director of Mental Health Services also granted approval for the Capstone Project (Appendix E), and the project was delivered at the children services Impact program meeting room during the monthly staff meetings.

#### *Participants*

Participants include psychologists, psychiatric mental health nurse practitioners, nurses, social workers, licensed mental health therapists, and office staff.

#### *Recruitment*

Recruitment of the participants was done at the monthly children services staff meeting with a letter outlining the study and participation.



### *Instruments*

*Secondary Traumatic Stress.* A survey including the STSS pretest and DIQ was administered to 16 MHP, and after five weeks the STSS posttest was administered. The Secondary Traumatic Stress Scale (STSS) (Appendix F) developed by Bride et al. (2004), is a self-report instrument of 17 items, which uses a five-point Likert scale designed to measure specific symptoms of secondary stress reactions. These stress reactions parallel PTSD symptoms of intrusion, avoidance, and arousal in helping professionals exposed to traumatized clients. The STSS targets three domains of secondary exposure to trauma: intrusion, avoidance, and arousal. The STSS was designed to correspond directly to the 17 symptoms of posttraumatic stress disorder (intrusion, avoidance, and arousal) delineated in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revision (Bride et al., 2004).

In a study with 287 social workers, the STSS has shown evidence of convergent, discriminant, and factor validity, including Cronbach alpha levels, on subscale as well as total STSS scores as follows: Intrusion = .80, Avoidance = .87, Arousal = .83, Total Scale = .93 (Bride et al., 2004). The confirmatory factor analysis of the STSS confirmed the data fit the priori hypothesized three-factor model of intrusion, avoidance, and arousal. The Goodness of Fit Index was .90, the Comparative Fit Index was .94, the Incremental Fit Index was .94, and the root mean square error of approximation was .069 (Bride et al., 2004). In Dominquez-Gomez and Rutledge (2009), the STSS achieved internal consistency reliabilities of .92 for intrusion, .92 for avoidance, .92 for arousal subscales, and .91 for the total scale in (n = 67) emergency room nurses.

Participants were instructed to read each item and indicate how frequently the item was true for them in the past seven days using a five choice Likert-type response

format ranging from 1 (never) to 5 (very often). Each item on the STSS corresponds to one of the 17 post-traumatic stress disorder (PTSD) symptoms in the *DSM IV-TR*. The STSS is comprised of three subscales: intrusion (items 2, 3, 6, 10, 13), avoidance (items 1, 5, 7, 9, 12, 14, 17) and arousal (items 4, 8, 11, 15, 16). These subscales respond respectively to B, C, and D criteria for PTSD. Total scores and each subscale are obtained by summing the items associated with each. A cutoff score of 38, which is at the lower threshold of the moderate range, is recommended (Bride, 2007).

*Demographic Information Questionnaire.* In addition to STSS, participants were asked to complete a 23-item survey (DIQ) (Bride, 2007). The DIQ requested standard demographic information regarding the participant's age, gender, income, professional activities, experience, highest degree earned, average hours worked, field of practice, and work related activities (Appendix G). Also in the DIQ, there are three self-anchored rating scales that asked participants to rate on a 5-point Likert scale the extent to which the client population is traumatized, the extent work addresses issues related to trauma, and the extent to which the participants experienced fear, helplessness, or horror in response to traumatic experiences reported by clients. The items analyzed for this study include items 1-6 and 19-22.

### *Procedure*

*Pre-Phase.* During the Pre-phase of the program, light refreshments were made available to all potential participants during the monthly staff meeting. A copy of the oral presentation was given to all mental health professionals and read verbatim by the project investigator (Appendix H). An auditor witnessed the reading of the oral presentation to the potential participants. The auditor and the project investigator signed and dated the oral presentation form. Signed copies were provided to the potential

participants indicating that the information was properly reviewed. Following the oral presentation, participants had the option to accept or decline participation in the program. No participants declined participation in the program. Those subjects willing to participate in the program were asked to provide informed consent (Appendix I) for which signatures were obtained and witnessed by the same auditor who witnessed the oral presentation. After an explanation of the study was provided and all questions were answered by the project investigator, signed and witnessed consent and oral presentation forms were collected by the investigator and concealed in a manila envelope and afterwards, placed in an unlabeled, locked storage box.

*Phase I.* The investigator delivered a PowerPoint presentation and information regarding secondary traumatic stress was given (Appendix J). The project investigator also addressed information on secondary stress prevention strategies and STS prevention plan (Appendix K).

The project investigator then distributed a STS Workshop Packet folder to participants with the following documents enclosed: Secondary Traumatic Stress Scale (pretest), one DIQ, and a workshop evaluation form (Appendix L). A numerical code was affixed to the inner left tab of each participant's folder with the pretest and posttest STSS and DIQ. To assure the protection of their identities an arbitrary numerical code was placed on all required documents. Also, a ticket used for a prize drawing at the conclusion of the program was placed inside of the right tab of each folder. After distributing the folders with the enclosed documents to the participants, program objectives were reviewed. Participants were asked to complete the STSS and the DIQ. After the participants completed the STSS and the DIQ, the forms were collected by the investigator, reviewed for completeness and proper coding by the participants, and

placed in a manila envelope that was afterwards placed in an unlabeled, locked storage box. The STS Education Program was then delivered by PowerPoint presentation and included definitions and theoretical framework related to STS. Levels of prevention for STS included prevention for the individual, employer, and the advocacy group. Awareness, Balance, and Connection was discussed and is essential in minimizing and preventing STS. The objectives and the plan for evaluating the STS Education and Prevention plan were explained.

The participants completed a secondary traumatic stress plan with the prevention plan format provided. Two hours was allotted for the Pre-phase and Phase I of the program for the oral presentation, informed consent, completion of the STSS and DIQ.

*Phase II.* The project investigator distributed a STS Workshop Packet folder to participants with the following documents enclosed: Secondary Traumatic Stress Scale (posttest) and workshop evaluation form. Participants were given an evaluation form to obtain input and feedback concerning the structure and content of the secondary traumatic stress intervention program as it relates to the mental health professionals knowledge of the topic, information provided, and methods of delivery. The STSS posttest and the evaluation form collected by the investigator was reviewed for completeness and proper coding by the participants and placed in a manila envelope that was later placed in an unlabeled, locked storage box. A numerical code was affixed to the inner left tab of each participant's folder for each STSS posttest. This arbitrary numerical code was placed on all required documents to assure the protection of their identity.

*Evaluation Phase.* A brief discussion of the program and the content provided immediately followed the STSS posttest, and evaluation forms were collected and

secured. Participants were allowed to discuss their STS prevention plans and ask any additional questions or provide any comments regarding the program. Participants were informed that the investigator was available, for up to 30 minutes, following the program to answer any additional questions on an individual basis.

Phase I lasted for two hours; Phase II and the evaluation phase of the program lasted one hour. A 15 minute break was scheduled following the first hour of each phase. Fifteen minutes was allotted following the program for completion of the prize drawing and closing remarks. Three hours (180 minutes), the maximum time required, was requested for the participants to successfully complete the program.

There was no monetary compensation offered for participation in this program; however, each participant was provided the opportunity to win grand prizes through a prize drawing, which was held during the closing remarks of Phase I and Phase II of the program. Participants were asked to remove their tickets from the right tab of their STS Workshop Packet. A program participant was randomly selected by the investigator to draw a ticket from a basket of tickets that correspond to the numbers on the tickets previously placed in each STS Workshop Packet. The selected participant announced the winning number aloud, and the winner was presented with the grand prize. The prize drawing was done as a token of appreciation to the participants of this program. The investigator provided the mental health facility Program Director and Executive Director each with a gift of appreciation for allowing the conduction of this program at their facility.

#### *Ethics and Human Subject Issues*

The University of Southern Mississippi Institutional Review Board (IRB) approval was obtained (Appendix M) prior to project implementation. Minimum risks

were involved in participation in this project. Participants' names were not used in data collection forms. In order to protect the identity of all participants by assuring confidentiality and anonymity, all data collection documents including pretest, posttest, and demographic survey forms were coded. A unique numerical code was affixed to the inner left tab of each STS Workshop Packet folder given to the potential participants at the beginning of the program. The assigned numerical code was used to code all required documents. Full signatures were required for the informed consent form and this document was collected by the investigator as well as all other data collection documents. This document was witnessed and placed in a manila envelope during the presentation and afterwards placed in a locked storage box labeled Pre-Phase. During the presentation, additional data forms collected were placed in separate manila envelopes and placed in unlabeled, locked storage boxes.

Following the program, data was secured in an unlabeled locked storage box in the project investigator's home office, accessible only to the project investigator. Signed informed consent forms were locked in a separate box from the data. Participants' information is confidential, and no participant will be identified in dissemination of the findings through publications and presentations. Data will be destroyed after evaluation of the data is complete.

## CHAPTER III

### RESULTS

#### Analysis of Data

Pre and posttest data were analyzed using descriptive statistics. Data required for analysis of this project was collected from the Demographic Information Questionnaire (DIQ) and responses to the pretest and posttest Secondary Traumatic Stress Scale (STSS) (Bride et al., 2004). The STSS instrument was used to determine and measure secondary traumatic stress in mental health professionals who work with victims of child sexual abuse. The STSS scores were assessed prior to the program intervention with a pretest and five weeks later with a posttest. Some of the independent variables gathered in the demographics were not tested beyond basic descriptive analysis. The focus of the descriptive analysis is centered on the scoring of STS by the STSS. Reliabilities were calculated on the total pre and posttest STSS scores, the CronBach Alpha was .82 ( $n = 17$ ). Matched paired t-tests were used to compare pre and posttest scores.

#### *Sample Characteristics*

Analysis of the demographic information from the participants indicated the average age was 40, with a minimum and maximum range from 25 years old to 56 years old. The majority of the respondents were female (93.8%) and African American (53.3%), with the remaining Caucasian (46.7%). The majority (86.6%) of the MHP held diverse degrees, which included nursing, psychiatric mental health nurse practitioner, and the remainder of the sample were certified mental health therapists. The majority of the sample made less than \$35,000 annually (68.8%). One-fourth of the participants' household incomes were less than \$45,000 annually, and one-fourth ranged from

\$75,001 to \$85,000 annually. Table 1 shows the frequencies and percentages for the categorical demographic variables of gender, ethnicity, personal, and household incomes, and education.

Table 1

*Demographic and Professional Characteristics of Mental Health Professionals  
Responding to Secondary Traumatic Stress Syndrome Survey (N = 16)*

	N	M	SD	%
Age	16	40.31	11.282	
Gender				
Female	15	93.8		
Male	1	6.3		
Ethnicity				
African American	8			53.3
Caucasian	7			46.7
Other	1			6.3
Education				
BSW	1			6.7
MSW	1			6.7
Other	13			86.6
Income				
Personal Income				
Less than \$25,000	5			31.3
\$25,001-35,000	6			37.5
\$35,001-\$45,000	3			18.8
\$45,001-\$55,000	0			0
\$55,001-\$65,000	0			0
\$65,001-\$75,000	0			0
\$75,001-\$85,000	1			6.3
More than \$85,000	1			6.3
Household Income				
Less than \$25,000	2			13.3
\$25,001-35,000	2			13.3
\$35,001-\$45,000	5			33.3
\$45,001-\$55,000	1			6.7
\$55,001-\$65,000	0			0
\$65,001-\$75,000	1			6.7
\$75,001-\$85,000	2			13.3
More than \$85,000	2			13.3



### *Total Symptoms*

Scoring of the STSS was conducted summing the total STSS scale and each individual subscale. The STSS individual subscales will not be reported in this project. Utilizing Bride's (2007) categorical approach of STSS, 44% of the participants ( $n = 7$ ) experienced mild STS symptoms on both the pre and posttest. The overall mean score of the pretest is 34.12 ( $SD = 8.08$ ), posttest is 37.5, with a standard deviation of 12.08. According to Bride (2007), the individuals who obtain an STSS total score of 38 or higher are considered to have PTSD due to secondary traumatic stress. Of the current study sample, 37% of participants obtained a score of 38 or higher on the STSS posttest, with 31% of participants obtaining a score of 38 or higher on the pretest (see Table 2).

Table 2

*Distribution of Total STS Severity Among Participants ( $N = 16$ ) for Pre and Posttests*

Symptom Severity Level						
(Pretest)	N	STSS Score	%	(Posttest) n	STSS Score	%
Little to no STS	4	17-28	25%	3	17-28	19%
Mild STS	7	28-37	44%	7	28-37	44%
Moderate STS	3	38-43	19%	1	38-43	6%
High STS	2	44-48	12%	3	44-48	19%
Severe STS	0	49 and above		2	49 and above	12%

Among participants, total scores on the STSS ranged from 22 to 48 on the pretest and 24-70 on the posttest. The STSS total possible scores ranged from 17, indicating no secondary traumatic stress symptoms, to 85 indicating severe STS (Bride et al., 2004).

There is evidence of Secondary Traumatic Stress (STS) in the survey population, as measured by the total STSS score of 38, which is the lower threshold of the mid-range of possible responses (Bride et al., 2004; Bride, 2007).

An independent samples t-test was conducted to evaluate the STS symptoms comparing pretest to posttest total STSS scores. Table 3 shows the descriptive statistics related to the paired samples and tests.

Table 3

*T-Test: Paired Samples Test*

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pretotal	34.1250	16	0.08187	2.02047
	Posttotal	37.5000	16	12.08856	3.02214

Finally, the total STSS scores compared the means of the pretest and posttest, and the result was not statistically significant ( $t(15) = -1.102, p = .288$ ). These outcomes indicate that the total STSS mean scores for the posttest ( $M=37.50$ ) was higher than the means for the pretest ( $M=34.12$ ). These STSS mean scores are less than the mean cut score recommended by Bride (2007) as characteristic of Secondary Traumatic Stress Disorder (STSD). There is, however, evidence of secondary traumatic stress (STS) within the current sample. Forty-four percent ( $n = 7$ ) of the participants experienced mild symptoms of STS on the pre and posttest and may be experiencing negative effects of STS. A smaller number of participants (12%) on the STSS pretest were experiencing high to severe secondary traumatic stress symptoms, while on the

STSS posttest 31% of the participants experienced high to severe symptoms.

### Evaluation Plan

The goal of the intervention was to identify and educate about STS in mental health professionals, thus improving therapist-client interactions and improving patient care outcomes. The STSS was administered to identify mental health professionals at risk for STS (pretest) and was administered in five weeks (posttest) to evaluate for reduction of symptoms of STS post intervention (Appendix N). The outcomes of the intervention indicated no statistical significant change in total STSS scores upon receiving education and implementing a prevention plan for STS. A final report was summarized based on the data findings and provided to the Southwest Mississippi Mental Health Executive Director and Program Director of Children Services.

### *Program Evaluation*

Evaluation of the effectiveness of the program included workshop evaluations of the program objectives. The workshop evaluation form indicated the majority of participants (87%) on the pretest and (93%) on the posttest strongly agreed that the program met the objectives.

## CHAPTER V

### DISCUSSION

The following sections will discuss links between current findings and the literature, describe the strengths and limitations of the project and its application to practice, and highlight opportunities for future evaluation. The objectives of this project were to identify STS in mental health professionals who work with child sexual abuse victims and provide education to assist mental health professionals in developing a prevention plan against STS. The STSS was administered to identify mental health professionals at risk for STS (pretest) and readministered five weeks (posttest) later to evaluate for reduction of symptoms of STS post intervention. After implementation of the personal prevention plan, the MHP participants evaluated the effectiveness of the program by comparing pre and posttest scores on the Secondary Traumatic Symptom Scale (STSS).

#### Interpretation of Results

Although there was not a statistical significance difference in comparing the pre and posttest scores, 44% of the participants reported mild symptoms on the STSS pre and posttest. The mental health professionals in this study met the criterion for the diagnosis of STS with a 34.12 mean score on the STSS pretest and a 37.5 mean score on the STSS posttest. In this project, total STSS severity distribution ranged from 25% pretest and 19% posttest reporting little to no symptoms of STS, with 12% of participants' posttest reporting severe symptoms. There a correlation of a reduction in reported experiences of STS as it relates to the knowledge and understanding of STS. Thus, the pretest scores may be lower based on lack of knowledge related to the STS concept.

Each participant developed a personal STS Prevention Plan during Phase I and Phase II. The program evaluation indicated that the majority of the participants at the end of Phase I and Phase II strongly agreed that the program met the objectives identified.

The majority of mental health professionals (94%) pretest and (100%) posttest had experienced at least one STS symptom in the past week. Interpretation of STSS results is the core of the study, and the results indicated that mental health professionals engaged in direct practice with children who have had a traumatic experience, CSA, are likely to experience some level of STS symptoms. When compared to other studies, the results of this project indicated a slightly higher incidence of STS among MHP: 34.1% on the STSS pretest and 37.5% on the STSS posttest (Bride, 2007; Dominguez-Gomez & Rutledge, 2009). In one study (Dominguez-Gomez & Rutledge, 2009), 33% of emergency room nurses had the presence of STS, with 85% having at least one symptom of STS, and in another study (Dominguez-Gomez & Rutledge, 2009), 15% of social workers had the presence of STS, with 70% having at least one symptom of STS.

The literature has suggested that helping professionals, including nurses, social workers, child protection workers, and police, experience STS (Bride 2007; Dominguez-Gomez & Rutledge, 2009; Follette et al., 1994) and are more at risk of STS due to the empathetic engagement with clients (Pearlman & Saakvitne, 1995). In the empirical literature, there is a lack of consistency in measurement of the respective concepts, STS, VT, and CF (Bride et al., 2004; Figley, 1995). There is also an overlapping of concepts and terminology in the literature which adds to the confusion. Vicarious trauma, secondary trauma, burnout, and compassion fatigue have similar definitions in the literature, and the terms are often used interchangeably. The STS constructs continuum

addresses the importance of clarifying and defining each concept. The STSS identifies secondary traumatic stress based on the subscales of intrusion, avoidance, and arousal (Bride, 2007). Future preventative interventions may include reporting secondary traumatic stress utilizing the STSS that includes the three subscales. Progression of the negative responses that MHP experience with the exposure to clients' trauma narratives can be determined and interventions implemented based on the subscale scores. There is also a need to have studies that use STSS to measure the construct of STS in different populations.

Despite empirical evidence for STS in mental health professionals (MHP), STS may or may not occur automatically within all MHP treating trauma victims. The project included a wide range of mental health professionals, in efforts to identify STS. The STSS is a tool that is specific to the construct of STS and has been utilized in identifying STS in specific populations like social workers and emergency room nurses (Bride, 2007; Dominguez-Gomez & Rutledge, 2009). Past studies have used a variety of different tools that are difficult to generalize and compare one study to another. The STSS was chosen for this project to identify STS because it specifically measures the concept of STS. According to Bride (2007) the STSS correlates with the *DSM IV-TR* diagnosis for PTSD. So the question remains if the STSS scores can be translated to *DSM IV-TR* criteria for PTSD.

Identification and prevention of STS needs to be done with a larger population sample of varied mental health professionals in order to evaluate the presence and effects of STS on mental health professionals. Further evaluations will provide a better understanding of how working with child sexual abuse victims may impact mental health professionals across the STS constructs continuum.

Saakvitne and Pearlman (1996) discussed the cumulative exposure of traumatic material while Figley (1999) emphasized the rapid onset of STS symptoms that can occur with exposure to a single event. Chrestman (1995) reported that therapists who had secondary trauma exposure were able to recover after a short time rather than develop chronic STSD. Other variables on the demographic information questionnaire including personal stress, work stress, number of years of experience, time spent in therapy, the caseload, and time of exposure to the traumatic event, may be examined to determine differences in the variables and STSS scores. These variables have been examined in previous studies and were collected on the DIQ for this project.

Previous studies examined and reported the correlation between increased trauma caseload and increased psychological distress (Brady, Guy, Poelstra, & Brokaw, 1997; Chrestman 1995; Kassam-Adams 1995, Trippany et al., 2004; Townsend & Campbell, 2009). According to Pross (2006), it was recommended that therapists not only treat trauma clients or have reduced hours spent with trauma clients. Folette et al., (1994), reported personal stress and types of coping affect the development of PTSD symptoms; however, a correlation between psychological distress and trauma caseload was not found. Devilly, Wright, and Varker (2009) found that exposure to traumatic material did not affect the development of STS, but found that work-related stressors best predicted therapist distress.

Some studies reported a link between fewer number of years experience in the field and higher psychological distress (Beaton and Murphy 1995; McLean, Wade, & Encel, 2003). Kassam-Adams (1995) found that women are more likely than men to exhibit STS symptoms. Other studies examined and reported a correlation between personal trauma history and increased psychological difficulties (Kassam-Adams, 1995;

Pearlman & MacIain, 1995). The participants' responses for all demographic variables on the DIQ should be reported in future dissemination of the project. There is a need to explore differences related to gender, ethnicity, education, experience, trauma caseload, personal trauma, and different coping strategies related to STS.

### Limitations

The study was limited to self-reported STS symptoms, which may be different from nonrespondents' STS experiences. The STSS score is based on experiences in the past 7 days; STS could have cumulative effects or can occur after a specific event. Therefore, the STSS score could vary widely depending on the number of trauma cases and severity of experience with traumatic material in the past week. There were also limitations in accounting for uncontrolled variables like personal trauma history and STS. Uncontrolled variables may have affected self-reporting of STS.

The length of time between pretest and posttest may not have been long enough to implement the STS prevention plan. Increased awareness of and education about STS may have increased memories and stress related to traumatic experiences, thus increasing the STS posttest scores. Posttest scores on the STSS were slightly higher than the pretest, reflecting the possibility that when participants completed the STSS they were reminded of the traumatic experience. As Bride (2004) discussed, this could cause the scores between the STSS to elevate.

There is limited generalizability of the project results because the sample was not randomly selected and is a small sample size ( $n = 16$ ). The sample population for this project included MHP professionals that work with CSA victims within a specific outpatient mental health setting and geographic location. Demographic information collected indicated the respondents' average age is 40.31 ( $SD = 11.28$ ). The majority of



this sample was female (93.8%) and African American (53.3%). A majority of the MHP held other degrees (86.6%), 6.7% held bachelor's degrees in social work, and 6.7% held master's degrees in social work. An examination of the relationship between demographic information (age, gender, ethnicity, education, trauma caseload, and personal trauma history) and STS symptoms was not conducted in this project. Another limitation is not linking the demographic data to the corresponding STSS score. Predominantly female (93.8%) participants may not represent a clear picture of the experience of STS in male mental health professionals.

#### Implications for Practice

This project documents the presence of STS in MHP utilizing the STSS, a reliable (.82 CronBach Alpha) and valid tool. The literature supports the data that the helping professions suffer from STS more frequently due to their empathetic engagement with clients. Based on the increased incidence of sexual abuse in the child and adolescent population, the data would support that MHP who work with child sexual abuse are exposed to traumatic material (Figley, 1999; Saakvitne & Pearlman, 1996; Stamm, 1999). Empathetic engagement is the basis for establishing trust and rapport in the therapeutic therapist-client relationship. It is imperative that MHP are educated about STS and its potential negative effects. Increasing awareness about the concept of STS, identification of symptoms, prevention strategies, and organizational interventions will aid in the management and prevention of STS.

The project intervention was not statistically significant; there was no decrease in STSS scores when comparing pretest to the posttest scores. There is a possibility that with a longer and more intensive STS education program there may be a reduction in STS scores. These results may indicate the need for more in-depth STS prevention

strategies/intervention with the posttest administered two to three months later. The longer length of time to complete the posttest may give the mental health professionals the time to implement and incorporate the STS prevention plan. A STS prevention plan should include self-care activities to assist the MHP in establishing a balance of work, play, and rest. The plan should include three areas: awareness, balance, and connection. Peer support and supervision will assist the MHP in making connections, while also allowing empathetic engagement with the client.

According to Bell et al. (2003), organizational recommendations should include limiting the workload of trauma clients, providing a safe and comfortable work environment, providing trauma specific education, implementing/establishing peer support groups, maintaining effective supervision, and providing resources to promote employees' self-care. When necessary, supervisors should not hesitate to refer mental health professionals who suffer from STS to seek counseling. Potential strategies to prevent STS include stress management techniques, debriefing, team building exercises, balance of work and time to rest, exercise, massage, meditation, and increased staff awareness about STS. These organizational changes may be costly initially, but if secondary traumatic stress is not addressed this may lead to an increase in staff turnover and low morale. Organizations should make STS prevention a priority, which in turn would decrease staff turnover and burnout. Recommendations include organizational support and employee assistance as well as ongoing supervision and education to prevent STS in mental health professionals. In the future, mental health professionals should also be trained about the occupational hazards of STS. Educating MHP about STS will aid in its prevention but will also improve self-care STS prevention. Self-care

practices should include a collaborative approach between the organization and mental health professionals that they employ.

Implications for DNP practice include promoting evidenced-based practice innovation and establishing the DNP leadership role in mental health services related to secondary traumatic stress. As a DNP leader and expert in STS, education of MHP should take place not only in regional community mental health clinics, but also statewide. The consequences of not addressing secondary traumatic stress in mental health professionals could result in unnecessary physical and psychological distress, that in turn, may negatively affect the therapist-client interactions and ultimately client outcomes.

Organizational and systems leadership for DNP quality improvement should be implemented to assist mental health professionals in identifying secondary traumatic stress and establishing a STS prevention plan. Interdisciplinary collaboration is needed, as well as implementing health care policies that involve patient advocacy and organizational resources to assess, educate, and prevent secondary trauma in mental health professionals, thus improving health care outcomes. The organization will benefit from having emotionally healthy employees, less staff illness, a decrease in staff turnover and a increase in productivity.

### Conclusions

This project identified the presence and level of Secondary Traumatic Stress (STS) in mental health professionals who work with CSA victims and focused on strategies to prevent STS. The incidence of STS in the current sample is clinically significant, indicating that large numbers of MHP may be experiencing negative effects of STS, which may impair their ability to help clients who seek their services. The goal

of the intervention was to prevent STS in mental health professionals, thus improving therapist-client interactions. It is essential to train mental health professionals to recognize symptoms of STS and to develop a STS prevention plan. Preventive efforts will improve patient care outcomes in victims of CSA. The ability of mental health professionals to empathetically engage with the client without symptoms of STS may ultimately improve the therapeutic relationship.

## APPENDIX A

## CRITERIA FOR PTSD VS. STSD

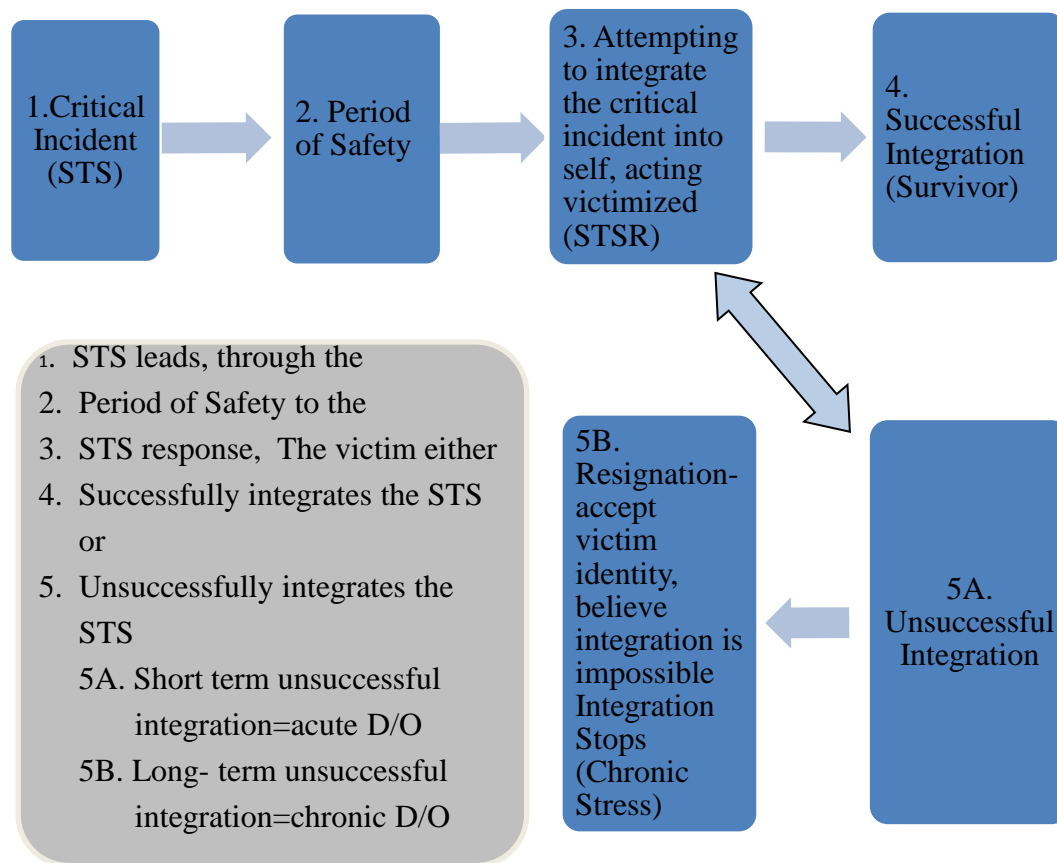
<b>POST TRAUMATIC STRESS DISORDER (PTSD) (DSM-IV)</b>	<b>SECONDARY TRAUMATIC STRESS DISORDER (STSD) (Figley, 1995)</b>
<p>1. Traumatic event causing one or both:</p> <ul style="list-style-type: none"> <li>A. Person who witnessed or confronted with event(s) which involve serious injury or death to self or others.</li> <li>B. Response of person who witnessed or confronted with event has intense feelings of fear, horror, or helplessness. Person may exhibit disorganized or agitated behavior.</li> </ul>	<p>1. Stressor is an abnormal event that is:</p> <ul style="list-style-type: none"> <li>A. Serious threat to traumatized person.</li> <li>B. Sudden destruction of traumatized person's environments.</li> </ul>
<p>2. Traumatic event is consistently relived in at one of the following ways:</p> <ul style="list-style-type: none"> <li>A. Intrusive recollections of the event (young children express repetitive play of aspects of the trauma)</li> <li>B. Distressing dreams of the event</li> <li>C. Reliving the event through illusions, hallucinations, dissociative flashbacks (young children may reenact the event).</li> <li>D. Intense psychological distress when exposed to cues that resemble a part of the event.</li> <li>E. Physiological reactions when exposed to cues that resemble a part of the traumatic event.</li> </ul>	<p>2. Reexperiencing traumatic event by:</p> <ul style="list-style-type: none"> <li>A. Recollections of the event</li> <li>B. Distressing dreams of the event</li> <li>C. Sudden reliving the event</li> <li>D. Reminders of the event</li> </ul>
<p>3. Persistent avoidance of cues that resemble the traumatic event as well as numbing of response to these cues (not present before the event) as indicated by at least three of the following:</p> <ul style="list-style-type: none"> <li>A. Efforts to avoid thoughts,</li> </ul>	<p>3. Avoidance or numbing responses to the traumatic event</p> <ul style="list-style-type: none"> <li>A. Avoids thoughts or feelings</li> </ul>

<p>feelings, or conversations associated with the event.</p> <p>B. Efforts to avoid activities, places or people that remind person of the event.</p> <p>C. Inability to recall an important aspect of the event.</p> <p>D. Markedly diminished participation in significant activities.</p> <p>E. Feelings of detachment or isolation from others.</p> <p>F. Restricted range of affect (e.g., unable to feel love, etc.)</p> <p>G. Sense of a shorten future or cannot see the future (career, marriage, children, or normal life).</p>	<p>B. Avoids activities or situations</p> <p>C. Psychogenic amnesia</p> <p>D. Decreased interest in activities</p> <p>E. Detachment from others</p> <p>F. Diminished affect</p> <p>G. Sense of shortened future</p>
<p>4. Persistent symptoms of increased arousal (not present before the event) as described by at least two of the following:</p> <p>A. Difficulty falling or staying sleep</p> <p>B. Irritability or anger outbursts</p> <p>C. Difficulty concentrating</p> <p>D. Hyper vigilance</p> <p>E. Exaggerated startle response</p>	<p>4. Persistent arousal</p> <p>A. Difficulty falling asleep/staying asleep</p> <p>B. Irritability or outburst of anger</p> <p>C. Difficulty concentrating</p> <p>D. Hyper vigilance</p> <p>E. Exaggerated startle reflex</p> <p>F. Physiologic reactivity to cues</p>
<p>5. Duration of the symptoms mentioned above lasts more than one month.</p>	
<p>6. Symptoms cause clinically significant distress or social, occupational, or other impairments.</p> <p>A. Acute if symptoms last less than 3 months.</p> <p>B. Chronic if symptoms last 3 months or longer.</p>	

Note: (American Psychiatric Association, 2000; Figley, 1995).

## APPENDIX B

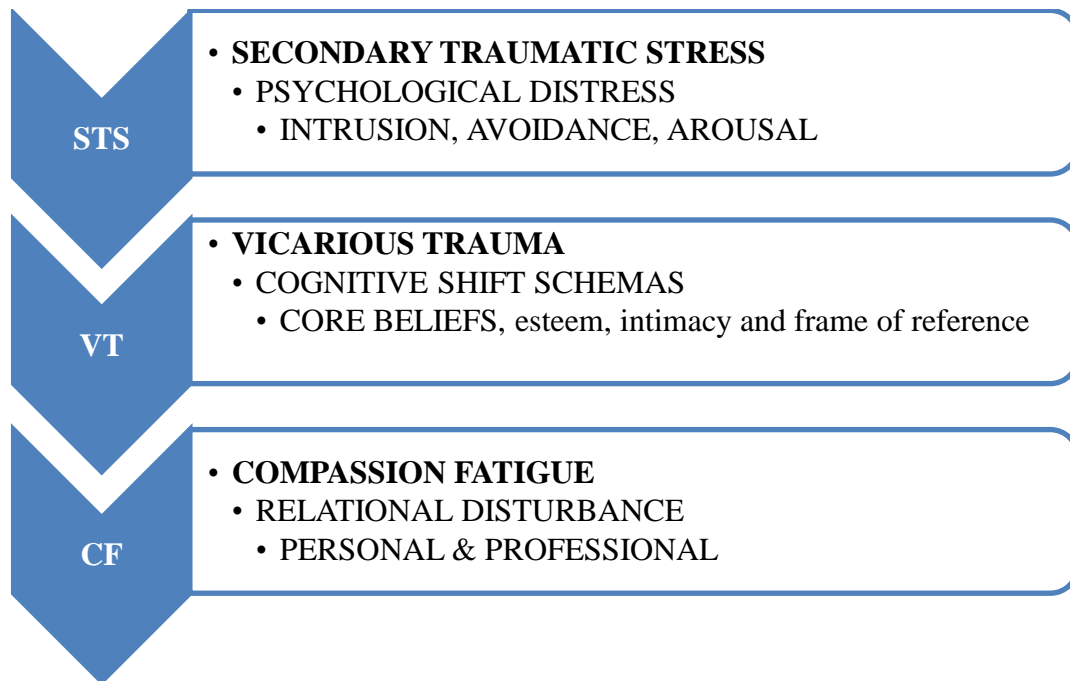
## ETIOLOGY OF THE INTEGRATION OF SECONDARY TRAUMATIC STRESS



Note: (Harris, 1995).

## APPENDIX C

## SECONDARY TRAUMATIC STRESS CONSTRUCTS CONTINUUM



This is a continuum or progression of negative responses that clinicians experience with exposure to trauma narrative/material (Adapted from Dutton & Rubinstein, 1995).



## APPENDIX D

## DNP ESSENTIALS AND CLINICAL IMPLICATIONS FOR THIS PROJECT

DNP ESSENTIALS	CLINICAL IMPLICATIONS
<p>DNP Essentials I-</p> <p>Scientific underpinnings for practice</p>	<p>The Integration of Secondary Traumatic Stress framework developed by Harris (1995) provides an understanding of STS in mental health professionals who work with victims of child sexual abuse. The model identifies factors that can influence the development of secondary traumatic stress. Within this framework STS reactions occur from inputs of exposure to traumatic events, use of coping strategies, and personal or environmental characteristics</p>
<p>DNP Essentials II-</p> <p>Organizational and systems leadership for quality improvement and systems thinking</p>	<p>Organizational and systems leadership for quality improvement will be addressed by identifying mental health professionals with secondary traumatic stress, educating them about this phenomenon and establishing a STS prevention plan. The prevention of secondary traumatic stress will improve client- therapist interactions thus improving client outcomes. The organization will benefit by emotionally healthy employees, less staff illness, decrease in staff turnover and increase in productivity.</p>
<p>DNP Essentials III-</p> <p>Clinical scholarship and analytical methods for evidence-based practice</p>	<p>Translates research into evidence-based practice utilizing quantitative data analyses. This project has opportunities to disseminate evidence-based findings regarding secondary traumatic stress to the healthcare community nationally and locally with written abstracts, training sessions, and poster presentations.</p>
<p>DNP Essentials IV-</p> <p>Information systems or technology and</p>	<p>Utilizes information systems and technology to review literature through web-based data searches and deliver these findings via power point presentations, excel and Microsoft</p>

patient care technology for the improvement and transformation of health care	office presentations.
DNP Essentials V- Health care policy for advocacy in healthcare	Involves patient advocacy and leadership in developing and implementing health care policy to improve health care outcomes in sexually abused children.
DNP Essentials VI- Interprofessional collaboration for improving patient and population health outcomes.	Includes interdisciplinary collaboration to assess, educate, and prevent secondary trauma in mental health professionals thus improving health care outcomes. Essential VII will involve risk reduction and prevention of secondary trauma thus improving health care outcomes.
DNP Essentials VII- Clinical prevention and population health for improving the nation's health	Involves risk reduction and prevention of secondary trauma thus improving health care outcomes.
DNP Essentials VIII- Advanced nursing practice	Utilizes advanced nursing practice in family and psychiatric mental health to implement education and prevention strategies for secondary trauma in mental health professionals who work with victims of child sexual abuse.

Note: (American Association of Colleges of Nursing, 2006).

APPENDIX E

LETTER OF PERMISSION FOR PROJECT IMPLEMENTATION SOUTHWEST  
MISSISSIPPI MENTAL HEALTH

**Appendix B**

**Granted Permission from Southwest Mississippi Mental Health**

SOUTHWEST MISSISSIPPI MENTAL HEALTH COMPLEX  
P.O. Box 768, McComb, MS 39649-0768 (601) 684-2173 FAX (601) 249- 4234



November 2, 2011  
University of Southern Mississippi  
School of Nursing  
Elizabeth Harkins Hall (EHH), 110  
118 College Drive, Box #5095  
Hattiesburg, MS 39406

To Whom It May Concern:

Abby McNeil, MS, FNP-BC, FPMHNP-BC is approved to complete her clinical training at Southwest Mississippi Mental Health Complex for her DNP capstone project. Her project involves prevention of secondary traumatic stress of mental health professionals who work with children that have been sexually abused.

Vicarious Trauma, or Secondary Traumatic Stress, often occurs in mental health professionals who work with children who have been sexually abused. Abby's plan includes the completion by staff of a trauma checklist prior to staff training on Secondary Trauma, and then completing another trauma checklist after the completion of the training as a post-test to evaluate the effect of the training.

According to prior studies, education about prevention of Secondary Trauma, along with the development of a prevention plan for staff most at risk, has been helpful in reducing staff burnout, staff turnover, and absenteeism, with concurrent improvement in performance by staff at risk.

We are looking forward to working with Abby on this project and anticipate that our staff will benefit by their participation in it.

Sincerely,

A handwritten signature in dark ink, appearing to read "Steve Ellis". The signature is fluid and cursive, with a large, stylized "S" at the beginning and a long, sweeping tail that extends to the right.

Steve Ellis, Ph.D.  
Licensed Psychologist  
Executive Director

## APPENDIX F

## SECONDARY TRAUMATIC STRESS SCALE

The following is a list of statements made by persons who have been impacted by their work with traumatized patients. Read each statement, then indicate how frequently the statement was true for you in the past seven (7) days by circling the corresponding number next to the statement

Never (1) Rarely (2) Occasionally (3) Often (4) Very Often (5)

1. I felt emotionally numb 1 2 3 4 5
2. My heart started pounding when I thought about my work with patients. 1 2 3 4 5
3. It seemed as if I was reliving the trauma(s) experienced by my patient(s). 1 2 3 4 5
4. I had trouble sleeping. 1 2 3 4 5
5. I felt discouraged about the future. 1 2 3 4 5
6. Reminders of my work with patients upsets me. 1 2 3 4 5
7. I had little interest in being around others. 1 2 3 4 5
8. I felt jumpy. 1 2 3 4 5
9. I was less active than usual. 1 2 3 4 5
10. I thought about my work with patients when I didn't intend to. 1 2 3 4 5
11. I had trouble concentrating. 1 2 3 4 5
12. I avoided people, places, or things that reminded me of my work with patients.  
1 2 3 4 5
13. I had disturbing dreams about my work with patients. 1 2 3 4 5
14. I wanted to avoid working with some patients. 1 2 3 4 5
15. I was easily annoyed. 1 2 3 4 5
16. I expected something bad to happen. 1 2 3 4 5
17. I noticed gaps in my memory about patient sessions. 1 2 3 4 5

NOTE. Reprinted with permission from Bride et al. (2004). Development and validation of the STSS. *Research on Social Work Practice*, 27, 33

## APPENDIX G

## DEMOGRAPHIC INFORMATION QUESTIONNAIRE (DIQ) (Bride, 2004)

INSTRUCTIONS: Please provide the following information.

1. Gender:           \_\_\_ Female   \_\_\_ Male
2. Current Age:     \_\_\_ Years
3. Ethnicity:       \_\_\_ African American                   \_\_\_ Native American  
                   \_\_\_ Asian/Asian American               \_\_\_ Multi-ethnic  
                   \_\_\_ Caucasian                               \_\_\_ Other (please specify)  
                   \_\_\_ Hispanic/Latino
4. Personal Income:   \_\_\_ Less than \$25,000                   \_\_\_ \$55,001-\$65,000  
                           \_\_\_ \$25,001 - \$35,000               \_\_\_ \$65,001-\$75,000  
                           \_\_\_ \$35,001 - \$45,000               \_\_\_ \$75,001-\$85,000  
                           \_\_\_ \$45,001 - \$55,000               \_\_\_ More than \$85,000
5. Household Income:   \_\_\_ Less than \$25,000                   \_\_\_ \$55,001-\$65,000  
                           \_\_\_ \$25,001 - \$35,000               \_\_\_ \$65,001-\$75,000  
                           \_\_\_ \$35,001 - \$45,000               \_\_\_ \$75,001-\$85,000  
                           \_\_\_ \$45,001 - \$55,000               \_\_\_ More than \$85,000
6. Highest Degree Earned:   \_\_\_ BSW/BSSW                   \_\_\_ Year granted  
                                   \_\_\_ MSW/MSSW                   \_\_\_ Year granted  
                                   \_\_\_ Ph.D./DSW                   \_\_\_ Year granted  
                                   \_\_\_ Other                       \_\_\_ Year granted
7. Total Experience (*Include only experience up to receipt of Masters Degree in post-Bachelors experience*)  
                           Social Work   \_\_\_ years   \_\_\_ months  
                           post-Bachelors \_\_\_ years   \_\_\_ months  
                           post-Masters   \_\_\_ years   \_\_\_ months
8. In a typical week, what is the average number of hours you work? \_\_\_
9. In a typical week, how many hours do you work in each setting below (*total = to item 8*)?  
                           \_\_\_ Public                               \_\_\_ Private Practice  
                           \_\_\_ Private,                           \_\_\_ non-profit Private,  
                           \_\_\_ Other                               \_\_\_ for profit (not private practice)
10. In a typical week, how many hours do you spend in fields of practice below (*total = to item 8*)?  
                           \_\_\_ Health Care                   \_\_\_ School Social Work  
                           \_\_\_ Mental Health               \_\_\_ Substance Abuse  
                           \_\_\_ Developmental Disability \_\_\_ Community Organization  
                           \_\_\_ Public Welfare               \_\_\_ Other (please specify)  
                           \_\_\_ Child Welfare
11. Length of time in current setting: \_\_\_ years   \_\_\_ months
12. Length of time in current position: \_\_\_ years   \_\_\_ months
13. During a typical week, number of hours spent in the activities below (*total = to item 8*)?

- \_\_\_ Direct client contact (i.e., face-to-face, telephone)
- \_\_\_ Client related activities (charting, treatment planning, case review, etc.)
- \_\_\_ Provision of clinical supervision to direct service providers
- \_\_\_ Other clinical activities not identified above
- \_\_\_ Research/Evaluation
- \_\_\_ Professional education
- \_\_\_ Administration/Management
- \_\_\_ Policy activities
- \_\_\_ Other non-clinical activities

14. During a typical week, hours spent in the following activities *related to traumatized clients*?

\_\_\_ **TOTAL HRS**

- \_\_\_ Direct client contact (i.e., face-to-face, telephone) with traumatized clients.
- \_\_\_ Client related activities (i.e., charting, treatment planning, case review, etc.)
- \_\_\_ Provision of clinical supervision to direct service providers related to traumatized clients
- \_\_\_ Other clinical activities not identified above related to traumatized clients
- \_\_\_ Research/Evaluation related to trauma issues
- \_\_\_ Professional education related to trauma issues
- \_\_\_ Administration/Management related to trauma issues

14. Hours spent in the following activities *specifically related to traumatized clients* (continued)?

- \_\_\_ Policy activities related to trauma issues
- \_\_\_ Other non-clinical activities related to trauma issues

15. In a typical week, how many individuals do you provide services to? \_\_\_

16. How many of those individuals are between the ages of {total should equal item 15)?

\_\_\_ 0-12 years \_\_\_ 13-17 years \_\_\_ 18 -55 years \_\_\_ 56 + years

17. Of those individuals served in a typical week (the number identified in item 15), how many have experienced the following traumas either as a child (prior to age 18) and/or as an adult (age 18+)?

**As a child**

**As an adult**

- |        |   |
|--------|---|
| a. ___ | ___ physical abuse or assault                                       |
| b. ___ | ___ sexual abuse or assault   |
| c. ___ | ___ combat or combat like situation                                 |
| d. ___ | ___ natural or man-made disaster                                    |
| e. ___ | ___ diagnosis of a life threatening illness                         |
| f. ___ | ___ diagnosis of family member/friend with life threatening illness |
| g. ___ | ___ life-threatening accident                                       |
| h. ___ | ___ any of the above traumatic events                               |
| i. ___ | ___ none of the above traumatic events                              |

18. Please indicate if you have personally experienced any of the following traumas either in the past year and/or in your lifetime:

**Past year****Lifetime**

- |          |       |   |
|----------|-------|---|
| a. _____ | _____ | physical abuse or assault                                       |
| b. _____ | _____ | sexual abuse or assault   |
| c. _____ | _____ | combat or combat like situation                                 |
| d. _____ | _____ | natural or man-made disaster                                    |
| e. _____ | _____ | diagnosis of a life threatening illness                         |
| f. _____ | _____ | diagnosis of family member/friend with life-threatening illness |
| g. _____ | _____ | life-threatening accident                                       |
| h. _____ | _____ | any of the above traumatic events                               |
| i. _____ | _____ | none of the above traumatic events                              |

19. Overall, to what extent is your client population traumatized?

- |            |        |            |          |               |
|------------|--------|------------|----------|---------------|
| 0          | 1      | 2          | 3        | 4             |
| not at all | mildly | moderately | severely | very severely |

20. To what extent does your work with clients address issues related to their traumatic experiences?

- |            |        |              |       |            |
|------------|--------|--------------|-------|------------|
| 0          | 1      | 2            | 3     | 4          |
| not at all | rarely | occasionally | often | very often |

21. To what extent have you experienced symptoms of depression?

- |            |        |            |          |               |
|------------|--------|------------|----------|---------------|
| 0          | 1      | 2          | 3        | 4             |
| not at all | mildly | moderately | severely | very severely |

22. To what extent have you experienced symptoms of anxiety?

- |            |        |            |          |               |
|------------|--------|------------|----------|---------------|
| 0          | 1      | 2          | 3        | 4             |
| not at all | mildly | moderately | severely | very severely |

## APPENDIX H

## ORAL PRESENTATION

My name is Abby McNeil and I am a Family and Psychiatric Mental Health Nurse Practitioner currently enrolled in the Doctor of Nursing Practice program at The University of Southern Mississippi. I have had the pleasure of working with the child and adolescent population in mental health for a significant period of time, in which I have acquired expertise in working with this population. Over the years, I have experienced symptoms of secondary traumatic stress and have witnessed the negative effects of STS in mental health professionals. In reviewing the literature, I have found that secondary traumatic stress is a phenomenon that occurs due to empathetic engagement with client trauma material. Little research and prevention strategies have been implemented to address secondary traumatic stress with mental health professionals who work with victims of child sexual abuse. The lack of training compromises the mental health professionals' level of self-efficacy potentially causing a disruption in their therapist-client interactions as well as causing STS symptoms in the therapist. This intervention has the potential to improve mental health professionals' productivity, and therapist-client interactions. Needless to say, I would like to extend this opportunity to you today.

1. **Purpose:** Secondary traumatic stress (STS) is an issue experienced by mental health professionals who are exposed to traumatic material and become at risk of becoming traumatized themselves. Mental health professionals working with sexually abused children are more vulnerable to STS due to their empathic engagement and level of exposure to trauma. STS can result in poor productivity, increase in staff illness, and turnover rates. The purpose of this project is to identify and prevent secondary traumatic stress in mental health professionals who work with child sexual abuse victims.
2. **Description of Study:** I am requesting your participation in this program today. There are three condensed phases integrated within this STS program. The Pre-phase consists of the oral presentation, which will provide potential participants with sufficient information concerning the program enabling them to accept or decline program participation. Following the oral presentation, potential participants will have the option to accept or decline participation in the program. Participants who decline to participate in the program will be asked to leave the designated area where the program will be presented. Individuals who are willing to participate in the program will be asked to provide informed written consent. During Phase I of the program a power point presentation will be delivered by the investigator and education on and prevention of secondary traumatic stress will be provided. Participants will be given a STS Workshop Packet folder containing a STSS pre-test to measure STS symptoms at baseline; a demographic information questionnaire to gain information concerning gender, age, race, education, income, trauma history, work experience, and current practice; and a program evaluation form to obtain feedback concerning the knowledge of the instructor, information delivered, methods of delivery, as well as suggestions and recommendations for future programs. The STSS pre-test and



demographic survey form will be completed during this phase. *Phase I* of the program will entail information concerning secondary traumatic stress symptoms, three domains of STS, prevention strategies, and completion of a personal STS prevention plan. *Phase II* of the program will take place 4 weeks later. The project investigator will then distribute the STS workshop packet folder to participants with the following documents enclosed: Secondary Traumatic Stress Scale post-test, and program evaluation form. The participants will complete the STSS post-test and program evaluation form. A numerical code will be affixed to the inner left tab of each participant's folder and will match the participant's identifier sheet in order to link data from the pre-test and post-test. . During the *evaluation phase* there will be a brief discussion about the program and content. There will be a review of the STS prevention plans and participants will complete a second personal STS prevention plan. During closing remarks, there will be a grand prize drawing as a token of appreciation for participation in the program. No more than three hours (180 minutes) will be required for total participation as time will be given for a pre-test, post-test, and evaluation.

3. **Benefits:** There are no guaranteed benefits that will result from participation in this program; however, there are potential benefits for participants. Potential benefits from program participation are improved knowledge and understanding of secondary traumatic stress in mental health professionals who work with victims of child sexual abuse. Participants may also develop adaptive coping strategies and a STS prevention plan. This intervention has the potential to improve mental health professionals' productivity, and patient client interactions. This intervention also may decrease staff illness, turnover, burnout, and stress.
4. **Risks:** Minimum risk is involved in the participation in this project. All key personnel responsible for the design and conduct of this project have received education on the protection of human research participants. Participation is voluntary and informed consent will be obtained from all subjects prior to conducting the program to assure voluntary participation. All participants have the right to withdraw informed consent during any part of the program without penalty. This study is related to effects of secondary traumatic stress of mental health professionals related to exposure of traumatic material. If any emotional distress is experienced by the participant a licensed psychologist will be available for debriefing or follow-up care for any identified psychological discomfort. In addition, there is always a risk that questions on the STSS pre or post test or those raised by participants will result in participants becoming uncomfortable or anxious. Participants will be reassured that this program is only intended to improve their level of knowledge and understanding of secondary traumatic stress and prevention.
5. **Confidentiality:** Any information obtained during participation in this program including informed consent, STSS (pre-test and post-test), demographic information questionnaire, and program evaluation form will be kept confidential. In order to protect the identity of all participants, confidentiality of all data collection documents including STSS (pre-test and post-test),

demographic information questionnaire, and program evaluation form will be coded by each participant. A unique numerical code will be provided to each participant in the STS Workshop Packet folder at the beginning of the training. The assigned numerical code will be placed on all required documents. During the workshop, collected data will be placed in separate manila envelopes and afterwards placed in locked storage boxes labeled *Pre-Phase*, *Phase I II*, and *Evaluation Phase* according to the phase in which they are completed. An identifier sheet with participants name and corresponding code will be maintained to link the pre-test and post-test data, and destroyed after the post-test has been administered. Coded data will be kept in an unlabeled locked box in the investigator's home office only accessible to the investigator. Signed informed consent forms will be stored in an alternative unlabeled locked box separate from other data collected.

6. **Alternative Procedures:** The alternative is not to participate in the study.
7. **Participant's Assurance:** This project has been reviewed by the Human Subjects Protection Review Committee at the University of Southern Mississippi, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research participant should be directed to the Chair of the Institutional Review Board at (601) 266-6820. Participation in this project is completely voluntary, and participants may withdraw from this study at any time without penalty, prejudice, or loss of benefits. Any questions or concerns about the research should be directed to Abby McNeil at (601) 695-3198 or Dr. Anita D. Boykins at (601) 266-5468.

---

Signature of Person Giving Oral Presentation

---

Date

---

Witness

---

Date

## APPENDIX I

## INFORMED CONSENT

THE UNIVERSITY OF SOUTHERN MISSISSIPPI  
AUTHORIZATION TO PARTICIPATE IN RESEARCH PROJECT

Participant's Name \_\_\_\_\_

Consent is hereby given to participate in the research project entitled Identification and Prevention of Secondary Traumatic Stress in Mental Health Professionals Who Work with Child Sexual Abuse Victims. All procedures and/or investigations to be followed and their purpose, including any experimental procedures, were explained by Abby McNeil. Information was given about all benefits, risks, inconveniences, or discomforts that might be expected.

The opportunity to ask questions regarding the research and procedures was given. Participation in the project is completely voluntary, and participants may withdraw at any time without penalty, prejudice, or loss of benefits. All personal information is strictly confidential, and no names will be disclosed. Any new information that develops during the project will be provided if that information may affect the willingness to continue participation in the project.

Questions concerning the research, at any time during or after the project, should be directed to Abby McNeil at (601) 695-3198 or (601) 581-8007 or Dr. Anita D. Boykins at (601) 266-5468. This project and this consent form have been reviewed by the Human Subjects Protection Review Committee, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research participant should be directed to the Chair of the Institutional Review Board, The University of Southern Mississippi, 118 College Drive #5147, Hattiesburg, MS 39406-0001, (601) 266-6820.

The University of Southern Mississippi has no mechanism to provide compensation for participants who may incur injuries as a result of participation in research projects. However, efforts will be made to make available the facilities and professional skills at the University. Information regarding treatment or the absence of treatment has been given. In the event of injury in this project, contact the Clinic Director Dr. Jody McIntyre, Southwest Mississippi Mental Health Children Services, for appropriate referral assistance at (601) 276-3040.

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of person explaining the study

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## APPENDIX J

### SECONDARY TRAUMATIC STRESS TEACHING PLAN

STS is similar to post traumatic stress disorder (PTSD)

According to Figley (1995), STS is a natural consequent behaviors and emotions resulting from knowledge about a traumatizing event that would be markedly distressing to almost anyone.

Secondary traumatic stress disorder occurs when there continues to be symptoms six months or more following the exposure to traumatic material.

Secondary traumatic stress reactions are described as symptoms one month or less in duration and considered a normal acute stress reaction.

#### STSD CRITERIA

Reexperiencing of trauma event, avoidance/numbing of reminders of event, and persistent arousal.

The avoidance phase includes efforts to avoid thoughts or feelings and activities related to the event, psychogenic amnesia, diminished interest in activities, detachment from others, diminished affect and a sense of foreshortened future.

The persistent arousal phase includes difficulty falling/staying asleep, irritability, difficulty concentrating, hypervigilance, exaggerated startle response and physiologic reactivity (Figley (1995).

#### EVALUATION OF STS

##### ASSESSMENT OF STS SYMPTOMS

Secondary Traumatic Stress Scale by Bride, B., Robinson, M., Yegidis, B., & Figley, C. (2004)

Rates how frequently symptoms are true for you in the past seven days.

#### DEVELOP A STS PREVENTION PLAN

##### LEVEL OF PREVENTION FOR STS

##### PRIMARY

##### INDIVIDUAL

BASIC SELF-CARE, REALISTIC GOALS & EXPECTATIONS

##### EMPLOYERS

REASONABLE WORKLOAD, ONGOING TRAINING, SUPERVISION,  
INVEST IN WORKER

##### ADVOCACY GROUP

REDUCE VICTIMIZATION/VIOLENCE IN COMMUNITY, AFFIRM  
MENTAL HEALTH WORKERS, ENCOURAGE AGENCIES TO VALUE  
WORKERS OVER PROFITS

#### SECONDARY TRAUMATIC STRESS TEACHING PLAN

## SECONDARY

## INDIVIDUAL

SELF CARE, ONGOING TRAINING/EDUCATION, SEEK PEER  
CONSULTATION/SUPERVISION

## EMPLOYERS

CREATE ENVIRONMENT THAT VALUES EMPLOYEES, PROVIDE  
OPPORTUNITIES FOR SUPPORT

## ADVOCACY GROUP

RAISE AWARENESS, PROVIDE TOOLS & TECHNIQUES FOR  
COPING, SUPPORT FOR MENTAL HEALTH WORKERS, ADVOCATE  
FOR FAIR SALARIES & BENEFITS

## TERTIARY

## INDIVIDUAL

SELF-CARE, SEEK EMOTIONAL SUPPORT/THERAPY, EXPRESS &  
PROCESS FEELINGS, DEAL WITH COGNITIVE CONFLICT

## EMPLOYERS

PROVIDE OFF-SITE SHORT TERM THERAPY

## ADVOCACY GROUP

PROVIDE ONGOING TRAINING ON COPING WITH STSD

By Yassen (1995)

## MINIMIZING STSD

## PRACTICE A B C

## AWARENESS

*BE AWARE OF WHAT YOU ARE DOING*

*KEEP YOUR MIND AND BODY IN THE SAME PLACE*

## BALANCE

*FIND THE RIGHT BALANCE FOR YOUR WORK AND THE REST OF LIFE*

## CONNECTION

*CONNECT WITH OTHER PEOPLE AS WELL AS WITH YOUR SPIRITUAL  
SELF*

## EVALUATE STS SYMPTOMS

AFTER 5 WEEKS OF INSTITUTING PREVENTION PLAN

RETAKE THE ASSESSMENT OF STS SYMPTOMS

REEVALUATE EVERY MONTH

Note: (Headington Institute, n.d.)

## APPENDIX K

## SECONDARY TRAUMATIC STRESS PREVENTION PLAN

A STS prevention plan is important in assisting mental health professionals to improve the therapist's client interactions and patient care outcomes. The prevention plan is from the Headington Institute (n.d.) and their supportive work with humanitarian and relief workers. The prevention plan consists of seven questions with various subcomponents. It is suggested to keep a log of these questions and reevaluate these every month. The questions follow:

QUESTIONS
1. List important risk factors for secondary traumatic stress (ex: person, work-related, cultural).
2. List any symptoms you are experiencing as it relates to secondary traumatic stress such as physiological, psychological, social, behavioral, and spiritual.
3. List things that you can do to cope better with these symptoms physically, psychologically, socially, (ex: escape, rest, play).
4. Identify steps that you could take during work as well as outside work that can help transform your secondary traumatic stress on a deeper level? (nurturing a sense of meaning and hope)
5. Develop two specific, realistic goals as it relates to questions 3 & 4 to implement weekly. Include how, when, where in developing goals.
6. List any obstacles that may get in the way of you doing the goals identified in question 5.
7. Describe what you could do to overcome any obstacles listed and what support is needed in accomplishing your goals (support systems).

Note: (Headington Institute, n.d.).

## APPENDIX L

## WORKSHOP EVALUATION

## Secondary Traumatic Stress Education and Prevention Program

Please rate the workshop on a Likert scale from 1 (lowest) to 5 (highest). Circle the number that best applies regarding your experience and opinions of this workshop.

**1 Disagree    2 Somewhat Disagree    3 Neutral    4 Somewhat Agree    5 Agree**

- The instructor was well prepared for the workshop session(s).  
1       2       3       4       5
- The instructor answered questions carefully and completely.  
1       2       3       4       5
- The instructor used examples to make the materials easy to understand.  
1       2       3       4       5
- The instructor stimulated interest in the course material and made the program interesting.  
1       2       3       4       5
- The instructor was knowledgeable about the topics presented in the course.  
1       2       3       4       5
- The instructor was fair in dealing with the learners and treated them respectfully.  
1       2       3       4       5
- The instructor made learners feel comfortable about asking questions.  
1       2       3       4       5
- The instructor's use of technology enhanced the learning process.  
1       2       3       4       5
- I would recommend this course to other mental health professionals.  
1       2       3       4       5

Additional Comments/ Recommendations:

## APPENDIX M

## IRB APPROVAL




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**INSTITUTIONAL REVIEW BOARD**

118 College Drive #5147 | Hattiesburg, MS 39406-0001 Phone: 601.266.6820 | Fax: 601.266.4377 | [www.usm.edu/irb](http://www.usm.edu/irb)

**NOTICE OF COMMITTEE ACTION**

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

The risks to subjects are minimized. The risks to subjects are reasonable in relation to the anticipated benefits. The selection of subjects is equitable. Informed consent is adequate and appropriately documented. Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects. Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data. Appropriate additional safeguards have been included to protect vulnerable subjects. Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form". If approved, the maximum period of approval is limited to twelve months.

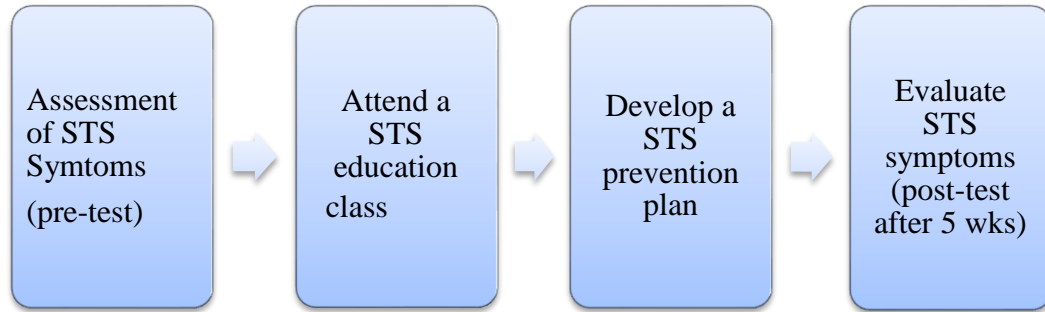
Projects that exceed this period must submit an application for renewal or continuation.

**PROTOCOL NUMBER: 12052304 PROJECT TITLE: Identification and Prevention of Secondary Traumatic Stress in Mental Health Professionals who Work with Child Sexual Abuse Victims PROJECT TYPE: New Project RESEARCHER/S: AbbyMcNeil COLLEGE/DIVISION: College of Health DEPARTMENT: Nursing FUNDING AGENCY: N/A IRB COMMITTEE ACTION: Expedited Review Approval PERIOD OF PROJECT APPROVAL: 05/29/2012 to 05/28/2013**

**Lawrence A. Hosman, Ph.D. Institutional Review Board Chair**



APPENDIX N  
PROGRAM EVALUATION PLAN



## REFERENCES

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